STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE COMMISSIONER OF HUMAN SERVICES

In the Matter of the Maltreatment Determination and Order to Forfeit a Fine for New Horizon Child Care Center, Inc.	**FINDINGS OF FACT, CONCLUSIONS, AND RECOMMENDATION**

This matter came on for hearing before Administrative Law Judge Barbara L. Neilson on October 24-26, 2006, at the Office of Administrative Hearings, 100 Washington Avenue South, Suite 1700, Minneapolis, Minnesota. The hearing record closed on December 5, 2006, upon receipt of final post-hearing submissions.

Jonathan Geffen, Assistant Attorney General, 445 Minnesota Street, Bremer Tower, Suite 900, Saint Paul, MN 55101-2127, appeared on behalf of the Department of Human Services ("the Department" or "DHS").

Thomas Hunziker, Attorney at Law, Dunkley and Bennett, P.A., 701 Fourth Avenue South, Suite 700, Minneapolis, MN 55415, appeared on behalf of New Horizon Child Care Center, Inc. ("New Horizon ").

STATEMENT OF ISSUES

1. Did the Department of Human Services appropriately determine that maltreatment of a child by neglect under Minn. Stat. § 626.556, subd. 2(c)(2), occurred on May 14, 2004, at New Horizon 's Elk River facility? If so, did the Department appropriately determine that New Horizon was responsible for the maltreatment and that a $1,000 fine should be imposed?

2. Did the Department of Human Services appropriately determine that maltreatment of a child by neglect under Minn. Stat. § 626.556, subd. 2(c)(2), occurred on February 22, 2005, at New Horizon 's Plymouth facility? If so, did the Department appropriately determine that New Horizon was responsible for the maltreatment and that a $1,000 fine should be imposed?

Based upon all of the proceedings herein, the Administrative Law Judge makes the following:

FINDINGS OF FACT

Background

1. New Horizon is a licensed child care provider in the State of Minnesota. It currently has approximately 60 child care centers in Minnesota.[1] It had approximately 53 facilities in Minnesota in 2002.[2] The two New Horizon facilities at issue in this matter are located in Elk River and Plymouth. Both of these facilities were opened in 2001 or earlier.[3]

2. Each licensed child care provider must renew its license and pay a licensing fee by December 31 each year. The Department sends out relicensing packets every year in approximately August or September.[4] If a facility does not complete its relicensing application, its license expires.[5] Because there is no evidence that New Horizon's Plymouth or Elk River facilities ever experienced a lapse in licensure,[6] it appears that those facilities received and completed their relicensing application that was due in 2002.

3. New Horizon obtains a separate license for each physical location it operates.[7] At New Horizon' s request, the reapplication packets for individual New Horizon facilities, including the Elk River and Plymouth facilities, have been sent to New Horizon's corporate office since at least 1999. Thus, approximately 53 separate relicensing packets were sent to New Horizon's corporate office in 2002.[8]

4. "Nursemaid's elbow" is a partial dislocation of a child's elbow joint that makes it difficult and painful to move the joint. Nursemaid's elbow typically occurs after a sudden pulling force is applied to the extended arm of a child.[9] If the head of the radius (which is one of the bones in the forearm) slips down and the ligament that is holding it there pops up into the joint, the ligament will get caught and obstruct normal motion at the joint.[10] In essence, "a portion of soft tissue, whose function is to hold bones together, is pulled between two areas of the bones that make up the elbow joint."[11] A child suffering such an injury often

[1] Transcript ("T.") 624, 652, 701.
[2] T. 701.
[3] T. 718.
[4] T. 503-04, 518-19, 642-43, 701; Ex. 55.
[5] T. 520, 639-40.
[6] T. 520, 639-41, 717-18.
[7] T. 520, 701.
[8] T. 489-92, 521, 624, 634-35, 643, 701-02.
[9] Ex. 65; T. 290.
[10] T. 288.
[11] Ex. 65 at 412.

becomes more susceptible to recurrence in the future, until they reach the age of four.[12]

5. Nursemaid's elbow is a common occurrence in young children below the age of four or five because the attachment of the ligament covering the head of the radius is weaker in children than in adults.[13] The symptoms of nursemaid's elbow include pain, refusal or inability to move the injured arm, and pain with movement.[14] A child who suffers nursemaid's elbow typically avoids moving or using that arm and holds the arm against his or her abdomen, slightly bent at the elbow.[15]

6. The most common cause of nursemaid elbow is axial traction by a pull on the hand or wrist, and the second most common mechanism of injury is a fall.[16] Nursemaid's elbow is "often seen after a parent lifts a child by one arm up a curb or high step."[17] The injury "can occur innocently from swinging a young child by the arms or pulling a child's arm while in a hurry."[18] Common situations in which this injury occurs include the following: a toddler and adult who are holding hands lurch in opposite directions, resulting in the toddler's hand being pulled; a toddler is pulled by the wrist up and over an obstacle; a child's arm is pulled through the sleeve of a sweater or coat; a child is caught by the hand to prevent a fall; a child is swung while being held by the hands; or a child falls suddenly and tries to catch himself while falling.[19] Tips for prevention of this injury include the following: "Avoid lifting a child by one arm only (from the wrist or hand) [but instead] [l]ift under the arm, from the upper arm, or both arms at a time;"[20] "Avoid any sudden jerking to the hand or forearm of any small child;"[21] and "Avoid pulling or swinging [a] child by the arms or hands."[22]

7. Parents of children with suspected nursemaid's elbow are generally advised to have the child seen by a physician and not attempt to correct the injury themselves.[23] Physicians usually reduce the dislocation by using one of two different methods: the wrist may be rotated externally and the arm extended, or the wrist may be rotated externally and the arm flexed at the elbow joint. The child experiences momentary pain when this type of injury is corrected, but it's over very quickly and anesthesia is never used.[24] Sometimes the injury is corrected by parents in the process of examining the child at home or when the

[12] Exs. 64, 65, 66; T. 293-94.
[13] T. 289, 291; Exs. 12, 64, 65, 66, 68.
[14] Exs. 12, 66.
[15] T. 293; Ex. 67.
[16] T. 233; Ex. 64 at 406.
[17] Ex. 12.
[18] Ex. 65.
[19] Exs. 12, 64, 65, 66, 68; T. 290-91, 303.
[20] Ex. 12.
[21] Ex. 65.
[22] Ex. 66.
[23] Exs. 12, 65, 66, 67, 68.
[24] T. 292-94; Exs. 12, 65, 67, 68.

child's arm is positioned for an x-ray.[25] With treatment, there is usually no permanent damage.[26] However, if nursemaid's elbow is left untreated, it may result in permanent inability to fully move the elbow.[27]

8. In approximately August of 2002, the Minnesota Department of Human Services ("the Department") prepared a document entitled "Alert – Dislocated Elbows" (hereinafter referred to as the "2002 Alert"). The 2002 Alert stated that the Department had investigated several incidents during 2001 and 2002 where children suffered dislocated elbows while attending licensed child care facilities due to child care staff lifting or pulling children by the wrist or hand.[28] To prevent similar injuries, the 2002 Alert required all licensed child care facilities to "read his alert, share it with your staff, and take precautions that you feel are the best fit for your program."[29] The 2002 Alert instructed facilities to "[p]lease alert your staff to the danger of dislocated elbows and take steps to prevent these types of incidents."[30] The 2002 Alert also provided tips to reduce the likelihood of this type of injury occurring, such as "never grab, drag, pull, yank, swing, or lift a child of any age by their arms or wrists" and "never swing children of any age by their arms."[31]

9. A copy of the 2002 Alert was included in the relicensing packet that the Department sent out in approximately August or September of 2002 to every child care facility that was in operation in 2002.[32] This was the only time that the 2002 Alert was sent out by the Department. Additional alerts on the same subject were not sent out by the Department until 2005 and 2006, after the incidents at issue in this case occurred.[33] The Department did not include the 2002 Alert in the 2004 relicensing packets.[34] No additional alerts pertaining to nursemaid's elbow were issued by the Department between August 2002 and September 2005.[35] The 2005 Alert explicitly stated that, "Although the areas of this alert and the corresponding suggestions are not requirements of child care center licensure, failure to consider these areas in the overall safety plan of your center may result in finding(s) of maltreatment under the Reporting of Maltreatment of Minors Act (Minnesota Statutes, section 626.556) should incidents occur."[36]

10. New Horizon has a Behavior Guidance Policy in place for its facilities. The policy that was in effect during 2004-05 stated that certain actions

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[25] T. 294.
[26] Exs. 12, 64, 65, 67, 68.
[27] Exs. 12, 67.
[28] *See* Exhibits (Exs.) 9, 33; T. 165.
[29] *Id*.
[30] *Id*.
[31] *Id*.
[32] Exs. 9, 33, 55; T. 62-63, 100, 461, 488-89, 503.
[33] T. 45, 49, 101, 503; Ex. 62 at DHS 278.
[34] T. 101.
[35] T. 103.
[36] T. 51, 111-13; Ex. 62 at 278, 279.

were prohibited, including: "Corporal punishment including, but not limited to, rough handling, shoving, shaking, excessive tickling, slapping, kicking, biting, pinching, hitting, spanking, and pulling arms, hair, or ears." Individuals who violate that policy are immediately terminated.[37]

11. New Horizon also posts a document entitled "Lifting Safely" in its facilities. The document sets forth steps to follow for healthy lifting when picking up, carrying, or setting down a child. It emphasizes the importance of bending at the knees and using leg muscles to do the work rather than straining one's back. Highlighted language at the bottom of the document states, "A healthy back is very important. Everyday our backs take on much unneeded wear and tear! Follow these simple procedures to reduce the extra stress on your back."[38]

Elk River Incident

12. In May of 2004, Gayle Fox was the Director of the New Horizon facility in Elk River. Ms. Fox was not the Director at the time the 2002 Alert was issued. She began working as director of the facility in approximately December of 2003. Before she became the director, she was employed at that location for five years as an infant room teacher.[39] Lisa Heidelberger worked as a teacher in the toddler room from approximately June of 2000 to July of 2005.[40] In May 2004, Stacy Haugen was a teacher's aide at the Elk River facility.[41] She first started part-time employment at New Horizon in September of 2003, and eventually became a full-time assistant teacher.[42]

13. Ms. Haugen received training on a number of subjects during her orientation at New Horizon when she was first hired in September 2003. Although some of the items on the orientation checklist that was in Ms. Haugen's personnel file were not checked off, several of those had to be completed during a timeframe that extended beyond the first week of employment, when the form was signed by Ms. Haugen and the then-director of the facility. Ms. Haugen did not see any videotapes during her initial orientation.[43] When Ms. Fox became director of the facility within a few months after Ms. Haugen started working at New Horizon, Ms. Haugen came to her with some questions about policies. Ms. Fox sat down with Ms. Haugen and conducted a thorough additional orientation with her, apart from CPR class, first-aid class, and corporate education, which were provided outside the facility.[44] Ms. Fox also gave Ms. Haugen an opportunity to watch the videotapes that were mandatory for orientation.[45] Other

[37] T. 585-86, 718-21; Ex. 21.
[38] Ex. 23.
[39] T. 194, 381-82, 425.
[40] T. 259.
[41] T. 140-41, 323.
[42] T. 196, 322-27, 348; Ex. 56 at 35.
[43] T. 348, 349, 365-66, 421, 435-36; Exs. 18, 56. Exhibit 56 is incomplete because it lacks the second page of the orientation checklist. That page is included in Exhibit 18.
[44] T. 420, 437-39.
[45] T. 430.

videotapes were presented by Ms. Fox at mandatory staff meetings.[46] Ms. Haugen testified that she believes one of the videos she reviewed within a few months after she began working for New Horizon and prior to the incident involving T.W. may have contained information about not lifting children by the hands, but it did not advise employees not to swing children around. She reviewed that video a few months after she began working for New Horizon, but before the incident involving T.W.[47]

14. The Elk River New Horizon is accredited by the National Association for the Education of Young Children (NAEYC). Its employees are trained on all of the accreditation standards, which the director presents at staff meetings.[48]

15. On May 14, 2004, T.W., an 18-month-old girl, was present in the toddler room. At approximately 3:30 p.m., Ms. Haugen and Ms. Heidelberger took the children outside to play. While playing with T.W., Ms. Haugen swung T.W. gently around in a circle one or two times. T.W. held on to Ms. Haugen's thumbs and Ms. Haugen wrapped her hands around both of T.W.'s wrists and lifted T.W. a few inches off the ground. Ms. Haugen then put T.W. down on the ground. T.W. was laughing and having fun, so Ms. Haugen picked her up again, this time under the armpits, to swing her around a second time. T.W. continued to laugh and giggle and did not express any pain or discomfort or ask Ms. Haugen to stop. Ms. Haugen never heard any popping noises from T.W.'s arm.[49]

16. Approximately ten minutes later, T.W. tripped and fell forward in a pile of woodchips around the playground slide. She used her hands to break her fall.[50] T.W. then went to play in the sandbox, and shortly thereafter, she started whining and favoring her right wrist.[51] It was only after T.W. fell that she started to cry and hold her arm close to her body.[52] Ms. Haugen thought at the time, and continues to believe, that T.W. injured her arm due to her fall.[53] Ms. Heidelberger told her that was possible, but it could be from having swung her around, and advised her that it was not a good idea to swing children.[54] Ms. Haugen was visibly upset when she heard this and said that she had no idea that a child's elbow or shoulder could be dislocated by being swung around.[55] Prior to this

[46] T. 431.
[47] T. 367, 369-70, 373; Ex. 58.
[48] T. 408-09; Ex. 58.
[49] T. 135-36, 230-31, 233, 243, 261-69, 310-11, 316, 335, 353-58; Exs. 1, 4.
[50] T. 230, 269, 311-12, 356, 360; Ex. 10.
[51] Ex. 1, pp. 2-3; T. 261-69, 311-12, 357.
[52] T. 233, 264, 356-57.
[53] T. 351, 358.
[54] T. 313, 331.
[55] T. 266-67, 271.

time, Ms. Haugen did not know that any injury could result from swinging a child.[56]

17. Ms. Haugen provided T.W. with an ice pack that she could place on her wrist.[57] Ms. Heidelberger and Ms. Haugen knew that T.W.'s mother would be coming shortly and assumed that they would not be able to reach her because she was probably en route, so they decided not to contact her.[58] Ms. Heidelberger left for the day shortly thereafter, at approximately 4:30 p.m. She told Ms. Haugen that she would need to write up an incident report for T.W.'s mother.[59] Both Ms. Haugen and Ms. Heidelberger believed that the injury occurred as a result of the fall and had nothing to do with the swinging.[60]

18. When T.W.'s mother arrived to pick her up around 5:00 p.m., T.W. was "huddled up against the building, kind of curled up in a ball with her [right] arm held in tight towards her stomach."[61] Ms. Haugen informed the mother that T.W. had fallen in the sandbox earlier and had been complaining that her arm or hand hurt, but it wasn't clear if the injury occurred then or before that time. She also said that she had not yet prepared an incident report because she was not exactly sure when the injury had occurred. T.W.'s mother told the caregiver that, because T.W. was "obviously injured," an incident report would need to be prepared. As T.W.'s mother was leaving, Ms. Haugen drafted an incident report. Because the director was not present at the facility at that time of the day on Friday, May 14, 2004, the report was not signed by the director until Monday, May 17, 2004.[62] The incident report did not mention that Ms. Haugen had swung T.W. around prior to the fall because Ms. Haugen did not realize that she could have dislocated T.W.'s arm by swinging her and didn't think that was what caused the injury.[63]

19. T.W. would not let her mother touch her arm after she picked her up. She cried when her mother tried to move her arm to put on her coat and when she buckled her into her car seat. Her mother took her directly to an urgent care. By the time the physician saw T.W., she was using both hands and playing well. T.W. had a normal exam. The physician manipulated T.W.'s arm by bending it upwards and T.W.'s mother thought she was 100 percent better after that. The physician told T.W.'s mother that she did not feel the elbow pop back into place so she was not completely sure that the arm had been dislocated. The doctor informed T.W.'s mother that an elbow dislocation may happen in a fall but more often occurs if a child is pulled by the arm**.** The doctor also warned T.W.'s

[56] T. 320, 329.
[57] T. 335; Ex. 3.
[58] T. 268-69, 316.
[59] T. 265, 316.
[60] T. 313.
[61] T. 136, 336-37.
[62] T. 136-38, 140-41, 312, 334, 338-39, 388; Ex. 3 at DHS 15.
[63] T. 339; Exs. 3, 15 at DHS 63.

mother that, once an injury of this type occurs, it is more likely to happen again.[64] The medical records from the urgent care indicate that T.W. was diagnosed with "possible radial head subluxation -- fixed." The physician later explained that radial head subluxation was the same as nursemaid's elbow, and the injury was described as "possible" because T.W. was using her arm during the exam and the physician's findings were "postulations" about what had occurred based on information provided by T.W.'s mother. The physician also indicated that sometimes nursemaid's elbow can resolve itself without a doctor's intervention.[65]

20. T.W.'s mother spoke to Ms. Fox on Monday, May 17, 2004, and told her that she had taken T.W. to the doctor and the doctor believed her arm had been dislocated. She also told Ms. Fox that the doctor had commented that this type of dislocation almost never occurs as a result of a fall. T.W.'s mother removed T.W. from New Horizon's Elk River facility and returned her to a Kinderberry Hill facility. Kinderberry Hill is also owned by New Horizon. T.W.'s mother did not learn that T.W. had been swung around in a circle on the day of the injury until she received a report later from the Department.[66] After leaving New Horizon, T.W. twice dislocated her right elbow in a similar manner.[67] At T.W.'s 18-month check-up on May 27, 2004, T.W.'s doctor told T.W.'s mother that this type of injury "rarely was the result of a fall" and that she "can almost be sure it was in a pulling incident."[68]

21. Ms. Fox discussed the incident involving T.W. with Ms. Haugen and Ms. Heidelberger on Monday, May 17, 2004. A short time later, Ms. Haugen told Ms. Fox that she had swung T.W. in a circle while playing with her on the playground. Ms. Fox told her that it was inappropriate to swing a child around and talked to her about appropriate ways to interact with children.[69] Ms. Fox also notified the facility's DHS licensor about the incident by telephone and fax on May 17, 18, 19, and 25, 2004.[70]

22. After the incident, Ms. Fox discussed the risk of dislocated elbows with staff at New Horizon-Elk River to ensure that everyone knew about it.[71]

23. As a result of the incident, Ms. Haugen was orally reprimanded by Ms. Fox concerning how to pick up a child and the need to avoid swinging or picking up children by their wrists. She was not given a written reprimand or suspension, or told that she had violated the Behavior Guidance Policy.[72] Ms.

[64] T. 142-47; Ex. 1 at DHS 3, Ex. 7 at DHS 27, Ex.14 at DHS 57.
[65] Ex. 1 at DHS 3; Ex. 7 at DHS 31.
[66] T. 144-45, 149, 258; Exs. 5, 14.
[67] T. 146-47.
[68] Ex. 1 at DHS 3, Ex. 7 at DHS 29.
[69] T. 390, 399, 402; Exhibit 14.
[70] Exs. 3, 4, 10; Exhibit 14.
[71] T. 273, 277, 279, 315; Ex. 16 at DHS 67-68.
[72] T. 337, 340, 352, 396-97.

Heidelberger did not receive any reprimand or other discipline with respect to the incident.[73]

24. A report was made to the Department of Human Services that a staff person at New Horizon had swung T. W. by her arms in a circle between one and three times resulting in T.W. sustaining a dislocated elbow.[74] After assessment by the intake department, the matter was assigned to Meghan McAlister for investigation. Ms. McAlister made a site visit and conducted interviews of Stacy Haugen, Lisa Heidelberger, and Gayle Fox on June 2, 2004. She also reviewed medical records and spoke to T.W.'s mother and the urgent care physician by telephone during the investigation. Ms. McAlister asked New Horizon for documentation of relevant training provided by the facility. She reviewed documents relating to the incident as well as the personnel and training files of Ms. Haugen and Ms. Heidelberger, the Employee Handbook, the Employee Safety Policy, the Behavior Guidance Policies, the Lifting Safely policy, and other documents provided by New Horizon.[75] Ms. McAlister was not provided and did not review videotapes that were used by New Horizon in training employees. She did not seek to interview the person who was the director of the facility in August 2002, when the 2002 Alert was issued.[76]

25. Prior to the incident with T.W., Ms. Haugen had not seen the 2002 Alert.[77] During her interview with Ms. McAlister, Ms. Haugen admitted that she did not know at the time of the incident that she was not allowed to swing children around or that they were able to get hurt by that activity. She said that Ms. Fox had since explained to her that she should not have swung T.W. by the arms.[78] Ms. Haugen indicated that she had not received any training on how to pick up a child other than CPR, first aid, and watching a videotape explaining the need to pick children up close to your own body. She said that she had never been informed during her training prior to the incident that she was not supposed to pick up children by their hands or wrists. Although Ms. Haugen had not previously received information from New Horizon regarding potential problems associated with swinging a child by his or her arms, she had received the information contained in the Behavior Guidance Policy (Exhibit 21) that she should not pull or tug on arms and she had also previously seen the "Lifting Safely" information sheet (Exhibit 23) which is posted at New Horizon.[79]

26. Lisa Heidelberger, the teacher in the toddler room, witnessed the incident with T.W. Ms. Heidelberger told Ms. McAlister that T.W. was "completely fine" after Ms. Haugen finished swinging her around and was

[73] T. 274.
[74] Ex. 1 at DHS 1.
[75] T. 153-54, 160, 162, 166-67,235, 326; Exs. 1, 6, 7, 11, 13, 18-23.
[76] T. 190, 194-97, Ex. 1.
[77] T. 340.
[78] Ex. 15 at DHS 61-62; T. 155-57, 330.
[79] T. 157-58, 331-33, 346, 362, 428; Exs. 15 at DHS 62, 21, 23, 56.

laughing and having a good time.[80] After the incident occurred, Ms. Heidelberger told Ms. McAlister that swinging a child could cause a dislocated arm, and Ms. Haugen was upset and said she had not known that.[81] Ms. Heidelberg had previously heard of the risk of dislocation of elbows or shoulders if children are swung around but cannot recall from whom. She is not entirely sure that a New Horizon staff member told her about this risk.[82] She told Ms. McAlister that New Horizon had provided in-service training to make sure staff knew appropriate ways to pick up a child, such as the importance of not picking up a child by their hands, bending your knees so you do not get hurt, and picking them up by their middle rather than their hands.[83] Ms. Heidelberger is fairly certain that she saw the 2002 Alert during her employment with New Horizon, although she acknowledged that she may have seen it at another day care facility.[84] She does not recall that New Horizon provided any training on dislocated elbows prior to the incident with T.W.[85]

27. During Ms. McAlister's interview with Ms. Fox, Ms. Fox informed her that swinging a child is not in accordance with acceptable behavior under New Horizon's policies and procedures. Ms. Fox indicated that, prior to the incident with T.W., Ms. Haugen "probably wouldn't have [known swinging was not allowed]. It's like biting, it's common sense."[86] Ms. Fox provided a copy of New Horizon's lifting instructions to Ms. McAlister and also told her that the Behavior Guidance Policies are part of an orientation packet that is discussed with new employees during orientation.[87] Ms. Fox told Ms. McAlister in a telephone conversation during the DHS investigation that she was not aware that she had ever seen the 2002 Alert.[88]

28. There is no evidence that New Horizon had a specific written or unwritten policy in May 2004 regarding playing with children by swinging them by the arms, and no evidence that Ms. Haugen had received training regarding dislocated elbows or swinging children by the hands.[89] None of the videotapes that New Horizon requires all employees to view as part of orientation provides information about not swinging a child around by the hands or wrists. The employee handbook also does not include such information, nor does the safety policy.[90]

29. Ms. McAlister completed her investigation into the Elk River incident within approximately two months, but did not issue her investigative

[80] T. 159-60; Exhibit 16 at DHS 65.
[81] Exhibit 16 at DHS 66.
[82] T. 161, 263, 313-14, 319-20; Exhibit 16 at DHS 67.
[83] T. 161-62; Exhibit 16 at DHS 67.
[84] T. 272, 316-18.
[85] T. 273, 277, 279.
[86] Exhibit 14 at DHS 58; T. 163.
[87] T. 163-65, 391, 394; Ex. 23.
[88] Ex. 7 at DHS 31; T. 403-04.
[89] T. 166-69, 235-36, 713; Exs. 1, 19, 21.
[90] T. 413, 431-32; Exs. 19, 20.

memorandum until almost sixteen months later due to priorities that she was required to apply in the completion of her work.[91] The Department is understaffed and has a significant backlog with respect to maltreatment investigations.[92]

30. Ms. McAlister ultimately recommended to her investigation manager, James Janacek, that the Department issue a finding of maltreatment by neglect with respect to the incident involving T.W. and that New Horizon be found culpable for the act of neglect.[93] Ms. McAlister determined that picking the child up by her hands and swinging her around put the child at risk of becoming injured. She recommended that New Horizon be found culpable because it did not have a policy or procedure in place for informing staff persons of the risks associated with that conduct.[94] Ms. McAlister's initial recommendation went to Mr. Janacek and Maura McNellis-Kubat, Section Supervisor for Investigations and Intake, for further review, and they ultimately agreed with her recommendation.[95]

31. On September 29, 2005, the Department issued a Determination of Maltreatment and Order to Forfeit a Fine as well as an Investigative Memorandum with respect to the incident involving T.W. The DHS concluded that maltreatment by neglect had occurred and that the facility was the responsible party. The Department ordered the license holder to pay a fine in the amount of $1,000 under Minn. Stat. § 245A.07, subd. 3(b)(4).[96] The Department explained its determination as follows:

> Although [Ms. Haugen] was the staff person who picked [T.W.] up by his/her hands and swung [T.W.] in a circle, [Ms. Haugen's] responsibility for the maltreatment was mitigated by the facility's responsibility to inform staff persons prior to the incident about the information related to dislocated elbows in the "Alert" issued in August 2002, including the advisement to "never swing children of any age by their arms."
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> The fact that the facility failed to provide [Ms. Haugen] with training regarding the "Alert" mentioned above was supported by [Ms. Haugen's] statement that s/he did not know s/he was not allowed to swing children and that s/he did not know that children could get hurt by being swung. [Ms. Fox], a facility supervisor, also corroborated the facility's failure to provide [Ms. Haugen] with the information in the "Alert" or other information regarding the dangers of swinging children by their arms when [Ms. Fox] stated that prior

[91] T. 188.
[92] T. 442.
[93] T. 171-72, 187; Ex. 1.
[94] T. 173-76; Ex. 1.
[95] T. 223-24.
[96] Exs. 1, 24.

> to the incident, [Ms. Haugen] "probably wouldn't" have known that swinging children by their arms was unacceptable.
>
> [Ms. Fox], who was responsible for providing training to all staff persons at the facility, stated that s/he was not aware of the "alert." A review of the facility policies and procedures and information from interviews showed that, at the time of this incident, the facility did not have a policy in place that prohibited staff persons from swinging children by their arms.[97]

32. The Department issued a Notification Memorandum dated October 5, 2005, directed to parents or guardians using the facility. The Notification Memorandum summarized the investigation finding and the DHS determination and order, and provided information about the action taken by the facility to inform staff how to prevent this type of incident from occurring again.[98]

33. During her investigation, Ms. McAlister determined that T.W. had suffered a dislocated elbow as a result of being swung around because she believed it was more likely than not that such an injury would be sustained from pulling on the arm rather than a fall. By the time of the hearing, she agreed that there is not a preponderance of the evidence to show that the dislocated elbow occurred as a result of being swung around.[99] Ms. McAlister has not been disciplined by the Department with respect to her investigative report regarding this matter. To date, no supplemental or corrected copy of the investigative memorandum has been issued.[100]

34. At the hearing, the Department stipulated that it could not prove by a preponderance of the evidence that the injury that occurred to T.W. resulted from Ms. Haugen swinging the child around in a circle.[101] The Department does continue to believe, however, that T.W. did, in fact, suffer a dislocated elbow on the day in question.[102]

35. Ms. McAlister did not refer to the 2002 Alert in any of the 3-5 other investigative reports she has prepared that involved allegations of a dislocated elbow.[103] In addition, in a 2005 investigation involving a different New Horizon facility, Ms. McAlister noted that staff persons hired to work at the facility "receive training in proper lifting procedures, behavior guidance, and additional facility policies," were "trained to pick up children by their torsos including their waists," and were "instructed that picking children up by their arms or leading children by their arms was not acceptable and can lead to injury such as a dislocated

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[97] Ex. 1 at DHS 7; Ex. 24 at DHS 137.
[98] Ex. 25.
[99] T. 179, 191-92.
[100] T. 474-75.
[101] T. 15, 33, 36, 37, 114, 116, 477, 483.
[102] T. 181, 229, 483.
[103] T. 186, 192.

elbow.[104] Staff persons at that facility were able to enunciate the training they had received.[105] In contrast, during the Elk River investigation, Ms. McAlister was not told that staff members were trained that picking children up by their arms or swinging them around is not acceptable and could lead to an injury, such as a dislocated elbow.[106]

36. There is no evidence and no allegation by the Department that Ms. Haugen was attempting to punish or hurt T.W. or was acting in a malicious manner.[107]

Plymouth Incident

37. Leah Brown started working at New Horizon in 2001. On February 22, 2005, Ms. Brown was employed full time as the lead teacher in the Busy Baby room at the New Horizon Plymouth facility.[108] Danielle Sanders was employed as the teacher in the Older Toddler room at the facility.[109] Tammi Martens was the Assistant Director of the facility from approximately 2001 to 2003, and Director of the facility from approximately 2003 to 2006. Jamie Lessard was the Assistant Director in 2005.[110]

38. New Horizon employees go through orientation when they first began working for the company. Ms. Martens conducts additional orientation if a New Horizon employee transfers to her facility from another location. Ms. Brown went through reorientation with Ms. Martens during the fall of 2003.[111]

39. On February 22, 2005, Ms. Brown was caring for four children between the ages of approximately 14 months and 17 months in the Busy Baby room.[112] Children in this age group are quite mobile, and these particular children were walking and running.[113] One of the children in Ms. Brown's classroom needed diapers. Parents are responsible for bringing diapers to New Horizon. Because the child had an older sibling in the Older Toddler room which was adjacent to the Busy Baby room, Ms. Brown decided to see if the sibling had diapers that she could use for his younger brother. Ms. Brown opened the back door that leads from her room to the older toddler room to speak with Danielle Sanders, the teacher in the Older Toddler room, about getting diapers. Ms. Sanders was standing at her changing table when Ms. Brown opened the door. As Ms. Brown opened the door, the four children in the Busy Baby room crowded around her feet, wanting to go through the open door. Ms. Brown stood in the

[104] T. 206-07; Ex. 63 at DHS 371.
[105] T. 239.
[106] T. 209, 211, 238-39.
[107] T. 158, 267, 330, 364, 396, 41.
[108] T. 529-530; Ex. 27 at DHS 6.
[109] Ex. 27 at DHS 6.
[110] T. 543, 576-77.
[111] T. 579-80.
[112] Ex. 27 at DHS 2.
[113] T. 552-53.

doorway and did not enter the other room. Ms. Sanders finished what she was doing and brought the diapers to Ms. Brown. While Ms. Brown was acquiring the diapers, a 17-month-old child, J.A.,[114] slipped between her legs and the door frame and entered the other room. At some point, Ms. Brown "grabbed him not hard" and "got ahold of his arm." She had her arm outstretched, and J.A. had his arm outstretched. J.A. went into the other room 2-3 feet. J.A. pulled against her and Ms. Brown did not want to let go because she was afraid that he would fall to the floor. Ms. Brown finished her conversation with Ms. Sanders, moved J.A. into the room, and closed the door.[115] All the children were a little upset because they didn't get to go into the other room. J.A. continued to cry, and Ms. Brown noticed after some minutes passed that he seemed to be favoring his arm. She checked his arm and it seemed to bother him. Ms. Brown asked another employee for help, and Ms. Martens responded. Ms. Martens obtained an ice pack for J.A. and Ms. Brown called his mother.[116]

40. Ms. Brown completed an incident report later that day, when the information was still fresh in her mind. In the incident report, she indicated that J.A. "snuck through the door" of the Older Toddler room while Ms. Brown was asking for diapers for another child and she "picked him up gently by his arms & moved him back in the Busy Baby Room."[117] The Director of the facility, Tammi Martens, asked her to write a statement regarding the incident, and she drafted such a statement very soon after the incident occurred. In the statement, Ms. Brown stated, "I took [J.] gently by the arms and moved him back through the door to Busy Baby Room. I don't know if I picked him up or just moved him."[118]

41. Danielle Sanders also prepared a statement after the incident. She stated that J.A. "was trying to get past [Ms. Brown] to come in the other classroom, when [Ms. Brown] gently moved him back. I never did see [Ms. Brown] pick up [J.A.] or hear [him] cry in pain."[119]

42. Ms. Martens sent an accident report to DHS the same day, and also wrote a brief statement reflecting what she had been told to send to licensing.[120] Ms. Martens also spoke with Ms. Sanders the day after the incident occurred. Ms. Martens' notes indicate that Ms. Sanders said that Ms. Brown "did not pick up the child. She either took him by the hand or put her hand on his chest or side and 'guided' him back into the room."[121]

43. Ms. Brown does not recall seeing the 2002 Alert or receiving any specific training prior to the incident about the risk of injuring a child's elbow if the

[114] J.A. is referred to as "J.H." in some of the documents. See, e.g., Exs. 27, 28.
[115] T. 530-34, 553-60; Ex. 27.
[116] T. 531, 538, 562, 581; Exs. 27, 38, 39.
[117] T. 531-32; Ex. 37.
[118] T. 539, 570-71 582-83; Ex. 38.
[119] Ex. 42.
[120] T. 584, 606; Exs. 35, 39.
[121] Ex. 39.

child is grabbed by the arm.[122] Her mother taught her when she was young not to lift a child by his or her hand or arm.[123]

44. After picking J.A. up on the day of the incident, Jeremiah's mother brought him to the Now Medical Center Urgent Care in Roseville, Minnesota, where he received treatment from Richard Sinda, D.O.[124] The notes from the medical visit indicate that J.A.'s mother indicated that the injury occurred when his day care provider quickly grabbed him to prevent him from being struck by a door. Dr. Sinda noted that the child was holding his elbow against his body and had pain at the right elbow when Dr. Sinda performed range of motion testing. He obtained an x-ray of Jeremiah's arm to ensure that there was no fracture of the elbow, and no fracture was seen. Dr. Sinda subsequently diagnosed Jeremiah with "subluxation of the radial head" of his right elbow, or "nursemaid's elbow," and performed a simple maneuver to put it back in place.[125] Dr. Sinda did not report Jeremiah's injury as suspected maltreatment because he had no reason to believe that was the case.[126] J.A.'s mother later reported the doctor's findings to Ms. Martens.[127]

45. Ms. Brown was not reprimanded or disciplined by New Horizon as a result of the incident. She was not told that she had violated any type of policy.[128] Ms. Martens did not consider Ms. Brown's conduct to warrant a sanction or to constitute a violation of the Behavior Guidance Policy.[129]

46. While working for another New Horizon facility in June of 2002, Ms. Brown had been issued a warning for rough handling of children.[130]

47. On February 28, 2005, DHS received a report that J.A. had sustained a dislocated elbow possibly when a staff person moved him out of a toddler room back to a baby room.[131] Judith Nass of DHS spoke to Ms. Martens on the telephone on March 1, 2005, regarding the incident. Ms. Martens told Ms. Nass that Ms. Brown could not remember whether she picked J.A. up by the arm or not, and Ms. Sanders said Ms. Brown did not pick up J.A. at all but either took him by the hand and moved him backwards or put her hand on his chest or side and guided him back into the room. In response to a question from Ms. Nass about what instructions staff persons are given related to lifting, Ms. Martens said

[122] T. 548, 550, 563; Ex. 32 at DHS 21.
[123] T. 563-64, 569-70.
[124] T. 286-89, 457; Ex. 48 at DHS 84.
[125] T. 288-89, 291-92, 297-98, 300; Exs. 36, 48.
[126] T. 300-01.
[127] T. 582.
[128] T. 543-44, 586, 606.
[129] T. 586, 606.
[130] T. 544-45, 564-65, 587-89; Ex. 57 at 144.
[131] Exs. 29, 30, 31; T. 67, 69-70, 612.

that they tell staff "if there is an unsafe situation and they need to move a child quickly, try to take them under the armpits."[132]

48. The Department initially issued a letter dated March 2, 2005, indicating that no further action would be taken by the Division of Licensing regarding the report.[133] Upon further review, the Department decided to assign the allegation for investigation of suspected maltreatment and sent a corrected letter to the concerned parties on March 11, 2004.[134]

49. Cynthia Gagne conducted the maltreatment investigation on behalf of the Department. Ms. Gagne did not testify at the hearing. She has moved out of Minnesota and no longer works for DHS. She did not have any disciplinary issues during her employment with DHS and was viewed as a good investigator by her direct supervisor, James Janacek.[135]

50. The investigative strategy form prepared by Ms. Gagne indicated that the allegation was one of physical abuse, and stated the "investigatory question" as being whether J.A. was "injured as a result of rough handling (pulling [him] by the arm) and was medical treatment necessary for the injury."[136] At some later point, the Department determined that the situation should be investigated as neglect as opposed to physical abuse.[137]

51. Ms. Gagne obtained copies of various documents during her investigation, including the doctor's report, Ms. Brown's written statement, the incident report prepared at New Horizon, facility policies regarding emergencies/first aid, J.A.'s emergency card, job descriptions, infant care policies, and child care guidance policies.[138]

52. As part of the investigation, Ms. Gagne made a site visit on March 31, 2005. She conducted interviews with New Horizon staff (Leah Brown, Danielle Sanders, and Tammi Martens) and took notes during the interviews.[139] Ms. Gagne also discussed the situation by telephone with the child's mother[140] and Tammi Martens.[141]

53. Ms. Gagne asked Ms. Martens during a telephone conversation in early August of 2005 whether Ms. Brown had been trained on the 2002 Alert or saw the Alert. Ms. Gagne's notes indicate that Ms. Martens "stated that she could not find any verification that [Ms. Brown] was trained on the information

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[132] Ex. 30 at DHS 15; Ex. 39.
[133] Ex. 50.
[134] T. 70, 450; Ex. 94.
[135] T. 444-46; Ex. 28.
[136] Ex. 32 at DHS 19, 20.
[137] T. 499; Ex. 27.
[138] T. 458-59; Exs. 37-38, 43, 44, 45, 46, 47, 48, 49.
[139] T. 451-52, 456, 535; Exs. 27, 34, 40, 41.
[140] Ex. 32 at DHS 20.
[141] Ex. 32 at DHS 21.

and/or if [Ms. Brown] saw the notice" and that Ms. Martens said that she herself did not recall receiving the 2002 Alert. Ms. Martens told Ms. Gagne that she had called New Horizon's corporate office to find out about the 2002 Alert and the corporate office had faxed a copy to her, which she then posted in the staff bathroom where all notices are posted for staff to see."[142]

54. During a telephone conversation on August 4, 2005, Ms. Brown informed Ms. Gagne that she was never shown the 2002 Alert prior to that moment, when she was reading it as she spoke to Ms. Gagne, and that she "was never trained on this information but wished that she had been prior to the incident."[143]

55. According to Ms. Gagne's notes of her interview with Ms. Brown, Ms. Brown said that J.A. "went thru the open door as I was standing there. I think I took him by the forearms & he was struggling. I was pulling him back into my room. He was walking. I'm not sure exactly how I moved him into the room. The other 3 children were also by my legs. When I pulled J. into room the children were all crawling over each other. . . . I believe I had put the diapers down & grabbed J. with both my hands. I didn't pick him up."[144]

56. According to Ms. Gagne's notes, Ms. Sanders reported during her interview that J.A. tried to crawl on his knees into the Older Toddlers room and Ms. Brown merely "put her arm down, not touching child, just as sort of a guide to stop him from moving further into my room. When he saw [Ms. Brown's] hand J. kind of stopped. She never had to even bend down to him to stop him."[145] DHS gave more credibility to Ms. Brown's report than to Ms. Sanders' report because Ms. Brown was directly involved in the situation and Ms. Sanders was not right there when the incident occurred.[146]

57. Ms. Martens did not personally provide training on injuries associated with pulling children by the arms or dislocated elbows, nor is there any evidence that materials addressing dislocated elbows were included in the training materials kept at the Plymouth facility.[147] Although she believes that her employees at Plymouth New Horizon were aware of problems associated with pulling arms and dislocated elbows prior to the incident involving J.A., she cannot point to any particular source that provided staff with that information.[148]

58. At Ms. Gagne's request, Ms. Martens provided Ms. Gagne with copies of all of the training materials she had available to her. The only

[142] Ex. 32 at DHS 21; T. 465-66, 490, 594-96, 606-07.
[143] T. 467, 594-96; Ex. 32 at DHS 21.
[144] Ex. 40.
[145] Ex. 41.
[146] T. 457, 485-86.
[147] T. 595, 600, 603-04.
[148] T. 607-08.

information in these training documents that addressed pulling on arms was the Behavior Guidance Policy.[149]

59. Prior to the incident involving J. A., both Ms. Brown and Ms. Martens attended first aid training that New Horizon offers through an independent company, Minnesota Medical Training Services. During the training session that she attended, Ms. Martens recalls being told that a child could be injured if he or she were pulled by the arms. However, Ms. Martens is not sure whether or not Ms. Brown attended the same session of the first aid training as she, and Ms. Brown never mentioned that this topic was covered in the training session she attended.[150]

60. Ms. Gagne submitted her proposed investigative report and recommendation to Mr. Janacek for review. In her report, Ms. Gagne found that Ms. Brown "pulled [JA] back into the 'Busy Baby Room.' [Ms. Brown] was unsure of exactly how [she] moved [J.A.], but remembered that [J.A.] was walking and the other three children that [Ms. Brown] was caring for were gathered around [Ms. Brown's] legs. . . . [Ms. Brown] said that [she] believed that [she] put the diapers down and grabbed [J.A.] using both of [her] hands."[151] Mr. Janacek substantially adopted Ms. Gagne's recommended findings, and Ms. McNellis-Kubat reviewed and approved the report.[152]

61. On September 29, 2005, the final version of the Investigation Memorandum was issued along with a letter notifying the parties that DHS had made a determination of substantiated maltreatment (neglect) by New Horizon's Plymouth facility.[153] The Department concluded that maltreatment by neglect had occurred because "[t]here was a preponderance of the evidence that [Ms. Brown] pulled [J.A.] by one or both arms as [he] went through an open door into another room and that the pulling of [J.A.'s] arm(s) resulted in dislocation of [his] right elbow." DHS found that the facility was responsible for the neglect and should pay a $1,000 fine.[154] In reaching this conclusion, the Department noted:

> [Ms. Brown] received orientation training at the facility that included the facility's philosophy, child care program, and procedures for maintaining health and safety, and handling emergencies and accidents. [Ms. Brown] also attended First Aid, CPR, and Safety Training provided by the American Hearth Association. However, [Ms. Brown] was not trained about the possibility of elbow dislocations from picking children up or pulling them by the hands and never saw the notice, *Alert – Dislocated Elbows,* that was sent out to all licensed child care facilities in August 2002. [Ms. Brown's]

[149] T. 597-98.
[150] T. 593-94, 610-11, 614, 731; Ex. 57 at DHS 125.
[151] Ex. 27 at DHS 2; Ex. 40.
[152] T. 448-49.
[153] Exs. 27, 52, 54.
[154] T. 448-49, 504-05; Exs. 27 at DHS 4, Ex. 52 at DHS 97.

> responsibility for the maltreatment of [J.A.] was mitigated by the facility's responsibility to train all staff persons on the alert regarding dislocated elbows sent out by the Division of Licensing.[155]

62. In considering the adequacy of the facility's policy and procedures, facility training, and individual's participation in the training, and in reaching its conclusion that New Horizon was responsible for the maltreatment, DHS found it significant that New Horizon had not passed along to its employees the information that had been provided by the Department regarding the fact that pulling a child's elbow, wrist, or arm created a condition that seriously endangers the child.[156]

63. The Department did not find that physical abuse occurred or that Ms. Brown intended to harm J.A. or was trying to punish him, and there is no evidence that that was the case.[157]

64. New Horizon's facilities have not received any citations that mention a failure to post or provide training with respect to the 2002 Alert. Between August 2002 and the end of February 2005, no DHS licensor asked Peggy Blackmon (New Horizon's Director of Licensee Center Support) if the facility had a copy of the 2002 Alert or mentioned the subject of the 2002 Alert. More recently, a DHS licensor told Ms. Blackmon that licensors are supposed to look for "signed off" copies of the version of the Alert issued in 2006 in staff files.[158]

Procedural Findings

65. New Horizon filed timely appeals of the Department's maltreatment determinations. The Department did not take action within 45 days of the request for hearing, and New Horizon commenced an action in Ramsey County to require the Commissioner to initiate this contested case proceeding.[159]

66. A protective order was entered in this matter on June 26, 2006. Under the protective order, disclosure of not-public data is permitted in the course of this case but is limited to parties' counsel, employees assisting counsel, and representatives and witnesses of the parties to the extent necessary to prepare and present claims and defenses or as required by court order. The not-public data may be used only for purposes of this proceeding and must be returned to counsel for the Department at the conclusion of this matter.

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[155] Ex. 27 at DHS 5; Ex. 52 at DHS 97.
[156] T. 473, 503.
[157] T. 500, 592-93.
[158] T. 628-30, 632-33, 672, 674-76, 677.
[159] T. 76-80; Exs. 26, 54.

67. The hearing in this matter was held as scheduled on October 24-27, 2006.

Based upon the foregoing Findings of Fact, the Administrative Law Judge makes the following:

CONCLUSIONS

1. This contested case proceeding is a consolidated hearing on two separate maltreatment determinations involving New Horizon's Elk River and Plymouth facilities and the two fines imposed by the Department as a result of its maltreatment determinations. The Administrative Law Judge and the Commissioner of Human Services are authorized to consider consolidated appeals of maltreatment determinations and fines that are assessed for violations.[160]

2. The Department of Human Services gave proper and timely notice of the hearing in this matter and has complied with all procedural requirements of law and rule.

3. Child care facilities licensed by the Department are required by the Department's rules to develop policies that contain "safety rules to follow in avoiding injuries, burns, poisoning, choking, suffocation, and traffic and pedestrian accidents."[161]

4. Pursuant to rules adopted by the Department, child care license holders must provide staff persons with orientation training that includes information about "the center's philosophy, child care program, and procedures for maintaining health and safety and handling emergencies and accidents," as well as their specific job responsibilities, behavior guidance standards, and reporting responsibilities under the Maltreatment of Minors Act and applicable rule.[162]

5. The purpose of the Maltreatment of Minors Act ("the Act") is to "protect children whose health or welfare may be jeopardized through physical abuse, neglect, or sexual abuse" and "make the home, school, and community safe for children by promoting responsible child care in all settings."[163]

6. Maltreatment of minors includes physical abuse, sexual abuse, and neglect.[164] "Physical abuse" is defined in part as "any physical injury, mental

[160] Minn. Stat. §§ 245A.08, subd. 2a, and 14.50.
[161] Minn. R. 9503.0110, subp. 3(B).
[162] Minn. R. 9503.0035, subp. 1; *see also* Minn. Stat. § 626.556 and Minn. R. 9503.0130.
[163] Minn. Stat. § 626.556, subd. 1.
[164] Minn. Stat. § 626.556, subd. 10e(a)(2).

injury, or threatened injury, inflicted by a person responsible for the child's care on a child other than by accidental means . . . ." Minn. Stat. § 626.556, subd. 2(g). "Neglect" is defined in part as a "failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so . . . ." The definition of neglect does not include a requirement that a child suffer an injury.[165]

7. After investigation of a report of maltreatment and a determination that maltreatment occurred, the investigating agency must determine whether the facility or individual was responsible for the maltreatment, or whether both the facility and the individual were responsible using mitigating factors set forth in the statute. Such determinations must be made based on a preponderance of the evidence.[166] The statute specifies that the investigating agency must consider at least the following mitigating factors in assessing the comparative responsibility of the facility and its employee:

> (1) whether the actions of the facility or the individual caregivers were according to, and followed the terms of, an erroneous physician order, prescription, individual care plan, or directive; however, this is not a mitigating factor when the facility or caregiver was responsible for the issuance of the erroneous order, prescription, individual care plan, or directive or knew or should have known of the errors and took no reasonable measures to correct the defect before administering care;
>
> (2) comparative responsibility between the facility, other caregivers, and requirements placed upon an employee, including the facility's compliance with related regulatory standards and the adequacy of facility policies and procedures, facility training, an individual's participation in the training, the caregiver's supervision, and facility staffing levels and the scope of the individual employee's authority and discretion; and
>
> (3) whether the facility or individual followed professional standards in exercising professional judgment.[167]

8. The Department has demonstrated by a preponderance of the evidence that maltreatment of T.W. by neglect occurred at New Horizon's Elk River facility on May 14, 2004, when she was swung around in a circle, and that the facility was responsible for the maltreatment. The Department's assessment of a fine of $1,000 for this maltreatment determination complies with Minn. Stat. § 245A.07, subd. 3(b)(4).

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[165] *Id*. at subd. 2 (f)(2).
[166] Minn. Stat. § 626.556, subd. 10e(e).
[167] Minn. Stat. § 626.556, subd. 10e(i).

9. The Department has demonstrated by a preponderance of the evidence that maltreatment of J.A. by neglect occurred at New Horizon's Plymouth facility on February 22, 2005, when he was pulled by one or both hands, and that the facility was responsible for the maltreatment. The Department's assessment of a fine of $1,000 for this maltreatment determination complies with Minn. Stat. § 245A.07, subd. 3(b)(4).

10. These Conclusions are reached for the reasons set forth in the attached Memorandum, which is incorporated by reference in these Conclusions.

Based upon the foregoing Conclusions, and for the reasons set forth in the accompanying Memorandum, the Administrative Law Judge makes the following:

RECOMMENDATION

IT IS HEREBY RECOMMENDED as follows:

1. The Department's determination that maltreatment by neglect occurred at the New Horizon-Elk River facility on May 14, 2004, and its further determination that the facility is responsible for that maltreatment and should forfeit a fine of $1,000 be **AFFIRMED**;

2. The Department's determination that maltreatment by neglect occurred at the New Horizon-Plymouth facility on February 22, 2005, and its further determination that the facility is responsible for that maltreatment and should forfeit a fine of $1,000 be **AFFIRMED**; and

3. The Protective Order entered in this matter shall remain in effect.

Dated: February 23, 2007

s/Barbara L. Neilson
BARBARA L. NEILSON
Administrative Law Judge

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Court Reporters

NOTICE

This report is a recommendation, not a final decision. The Commissioner of Human Services will make the final decision after a review of the record. The Commissioner may adopt, reject or modify the Findings of Fact, Conclusions, and Recommendations. Under Minn. Stat. § 14.61, the final decision of the Commissioner shall not be made until this Report has been made available to the

parties to the proceeding for at least ten days. An opportunity must be afforded to each party adversely affected by this Report to file exceptions and present argument to the Commissioner. Parties should contact the Appeals and Regulations Division, P.O. Box 64941, St. Paul, MN 55164-0941, to learn the procedure for filing exceptions or presenting argument.

If the Commissioner fails to issue a final decision within 90 days of the close of the record, this report will constitute the final agency decision under Minn. Stat. § 14.62, subd. 2a. The record closes upon the filing of exceptions to the report and the presentation of argument to the Commissioner, or upon the expiration of the deadline for doing so. The Commissioner must notify the parties and the Administrative Law Judge of the date on which the record closes.

Under Minn. Stat. § 14.62, subd. 1, the agency is required to serve its final decision upon each party and the Administrative Law Judge by first class mail or as otherwise provided by law.

MEMORANDUM

This is a consolidated hearing involving two separate maltreatment determinations and fines imposed by the Department. The Department determined in each instance that maltreatment by neglect had occurred for which New Horizon was responsible, and imposed a $1,000 fine. New Horizon filed timely appeals of both determinations and the resulting fines.

Maltreatment Determinations

The Department argues that maltreatment by neglect occurred on May 14, 2004, when Stacy Haugen, an employee of New Horizon's Elk River facility, grasped T.W., an 18-month-old child, by the hands and swung her around in a circle while playing with her on the playground. T.W. fell down approximately ten minutes later and thereafter was observed favoring her arm, and an urgent care physician subsequently found she had sustained a "possible" nursemaid's elbow. The Department stipulated at the hearing that it could not prove by a preponderance of the evidence that Ms. Haugen's actions led to T.W.'s injury.

The Department asserts that the act of swinging a child by her arms amounts to neglect under the Maltreatment of Minors Act because it placed the child in imminent danger of injury and constituted a failure to protect her from actions that seriously endangered her physical health despite the fact that the caregiver was reasonably able to do so. New Horizon argues in response that the DHS has not proven that swinging a child gently by the arms seriously endangered the child, and contends that DHS should have terminated its investigation and withdrawn its finding of neglect when it conceded that it could not establish by a preponderance of the evidence that the child was injured as a result of Ms. Haugen's actions.

The Maltreatment of Minors Act defines neglect as a "failure to protect the child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so."[168] Neither the definition of neglect nor the other provisions of the Act require that a child sustain an actual injury as a result of the alleged maltreatment; instead, they require only that the actions "seriously endanger" the child's health. Maura McNellis-Kubat, Supervisor of the DHS Intake and Investigations Section, testified that the Department has issued maltreatment determinations in many other cases in which no injury has occurred. For example, the Department has found that maltreatment has occurred if a child leaves a facility and is therefore at risk of harm even if no harm actually results, or if children are physically handled in such a way that they are placed at risk of injury but no injury in fact occurred.[169] Accordingly, it is concluded that the Department's inability to show by a preponderance of the evidence that T.W. was injured by Ms. Haugen's conduct does not render it impossible for the Department to show that maltreatment by neglect occurred.

Several medical resources received into evidence at the hearing support the Department's view that swinging a child by the arms or hands may cause a dislocated elbow.[170] In addition, Dr. Sinda acknowledged that it would be possible for a child to be put in danger of nursemaid's elbow by being picked up by the hands and swung around in a circle. He more typically sees the dislocation occur where there is a quick yank rather than a slow, steady force. Although he believes the injury would be unlikely to occur if a child is swung around slowly and "real gently," he stated that the injury could result if the child is swung rapidly.[171] In addition, based on DHS investigations conducted during 2001-02, the Department issued an Alert to licensees in 2002 as part of their relicensing packets which explicitly identified the danger of dislocated elbows associated with swinging children by their arms and included the following tips to reduce the likelihood of injuring a child's elbow: "never swing a child of any age by their arms" and never "grab, drag, pull, yank, swing or lift children" by their arms or wrists.[172]

There is also ample evidence that actions that may result in a dislocated elbow, such as swinging children in a circle, are properly viewed as actions that "seriously endanger" the child's health. Although the Maltreatment of Minors Act does not define what is meant by conditions or actions that "seriously endanger" the child's physical health, the definition of "serious maltreatment" contained in the portion of Chapter 245 relating to human services background studies provides some guidance on this issue. That chapter defines "serious maltreatment" to include "maltreatment resulting in serious injury which reasonably requires the care of a physician whether or not the care of a

[168] Minn.Stat. § 626.556, subd. 2(f)(2).
[169] T. 58.
[170] *See, e.g.,* Exs. 65, 66, 68.
[171] T. 291, 295, 302, 306.
[172] Ex. 33 at DHS 22.

physician was sought. . . ."[173] T.W.'s mother did, in fact, take her to an urgent care immediately after leaving New Horizon on the day of the injury, where a possible nursemaid's elbow was diagnosed. The medical references relied upon by both parties at the hearing noted that children suffering from nursemaid's elbow typically cry, experience pain in the affected elbow, and refuse to use that arm after the injury occurs. These references urged that children with suspected nursemaid's elbow be seen by physicians and that parents not attempt to reduce the dislocation themselves.[174] Although typically no permanent damage occurs if the condition is promptly treated, several of these references mentioned that, if left untreated, nursemaid's elbow could result in permanent limitations on the child's ability to fully move the elbow.[175] In addition, the injured child is more susceptible to future elbow injuries.[176] In fact, T.W. suffered two later dislocated elbows after her initial injury in May 2004.[177]

Accordingly, it is concluded that swinging a child by the arms or hands is an action that may result in a partial dislocation of the elbow which reasonably requires the care of a physician and, as such, "seriously endangers" the child's physical health. Although there is no question that Ms. Haugen was well-intentioned when she played with T.W. by swinging her in a circle, her actions under the circumstances amounted to maltreatment by neglect because she unwittingly placed T.W. at risk of sustaining a serious injury that would require a physician's attention.

The Department further contends that maltreatment by neglect occurred when a staff person at New Horizon's Plymouth facility pulled J.A., a 17-month-old child, by the arm on February 22, 2005, causing a dislocated elbow. J.A. cried and held his right elbow immediately after the incident. His mother was called and took him to an urgent care, where he was diagnosed with a dislocated elbow. The staff person, Leah Brown, indicated during the Department's maltreatment investigation that she believed the child, J.A., suffered the injury to his elbow when she took him by the forearms as he was struggling to go into an adjacent room containing older children and pulled him back into his own classroom. New Horizon contends that the Department has not shown that Ms. Brown pulled on the child's arm and thus has not proven that Ms. Brown seriously endangered J.A.

In the incident report she prepared on the day of the incident, Ms. Brown stated that she "picked [J.A.] up gently by his arms & moved him back in the Busy Baby Room."[178] In a lengthier statement dated the day after the incident occurred, Ms. Brown again stated that she "took [J.] gently by the arms and moved him back through the door to Busy Baby Room. I don't know if I picked

[173] Minn. Stat. § 245C.02, subd. 18(a).
[174] *See* Exs. 12, 65-68.
[175] Exs. 12, 67.
[176] T. 293, Ex. 67.
[177] T. 146-47.
[178] Ex. 37.

him up or just moved him."[179] During her interview with the DHS investigator approximately ten weeks later, Ms. Brown said, "I think I took him by the forearms & he was struggling. I was pulling him back into my room. He was walking. I'm not sure exactly how I moved him into the room. . . . When I pulled [J.] into room the children were all crawling over each other."[180]

Ms. Brown testified at the hearing that the statements she made at the time of the incident and during the DHS investigation about how she moved J.A. back into the room were merely based on "second guesses." She asserted that the incident occurred so quickly that she was not sure then or at the time of the hearing exactly how she moved J.A. back into the Busy Baby room. She is sure that she did not pick J.A. up to move him back into the room, but otherwise said that she does not recall exactly how she moved him or whether she grasped both of his arms. She asserted that the only clear memory she has is that she was holding J.A.'s arm and he pulled against her.[181] She further testified at the hearing that she did not pull J.A., and that, when J.A. pulled against her, that involved more pressure or torque than anything else that happened during the incident.[182] Ms. Brown stated that she did not want to let go of J.A. when he was pulling against her because he could have fallen on the floor or hit another door that was behind him and she did not want him to bump his head.[183] Ms. Brown also testified that she believed that she needed to keep J.A. from going into the toddler room for his own safety, since he was only 17 months old at the time and the children in the older toddler room were two years old and up.[184]

Because Ms. Brown testified that she was not clear as to various details, was "second-guessing" what happened, and was not even certain what happened immediately after the incident occurred, New Horizon argues that DHS has failed to meet its burden of proof to show that Ms. Brown pulled, lifted, or in any way caused the injury to the child's arm. New Horizon also argues that Ms. Brown's actions were reasonable and appropriate in any event, since she simply acted to prevent J.A. from going into an age-inappropriate area and leaving her supervision, and she did not want to let go of J.A.'s arm due to a fear that he would fall and possibly be injured. New Horizon thus asserts that Ms. Brown was reacting to a quickly unfolding, emergency situation, and was not reasonably able to protect J.A. from actions or conditions that placed him at risk of suffering a dislocated elbow.

The Administrative Law Judge concludes that the statements Ms. Brown made at or near the time that the incident occurred, when it was fresher in her mind, are more likely to accurately reflect what happened than the vague and inconsistent testimony she provided at the hearing 20 months later. Even if Ms.

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[179] Ex. 38.
[180] Ex. 40.
[181] T. 531, 537-38, 539-41, 551-52, 557-566, 567.
[182] T. 557-58.
[183] T. 538, 558.
[184] T. 542, 567, 570, 573-74, 605.

Brown was intimidated by the situation during her interview with the DHS investigator,[185] she prepared the written incident report and the February 23, 2005, statement herself and presumably was not put "on the spot" in preparing these documents but rather had time to reflect and ensure that her description was accurate. Ms. Brown's testimony that she was merely "second guessing" what happened, and only remembers that she grabbed J.A. by the hand and he pulled against her, is not convincing in light of its inconsistency with her earlier admissions that she took J.A. by the arms and pulled or moved him back into the baby room. Ms. Brown's testimony that J.A. pulled against her is consistent with her earlier report that he was struggling and wanted to go into the toddler room; however, her contention that he exerted more force than she did is not convincing given the differences in their sizes and the uncontroverted fact that she somehow managed to move the struggling child back into the Busy Baby room.[186] Accordingly, the Judge finds that the preponderance of the credible evidence demonstrates that Ms. Brown pulled J.A. by grasping one or both arms during the incident on February 22, 2005.

In addition, based upon the record as a whole, it cannot be concluded that Ms. Brown was faced with an emergency situation that required her to act quickly without thinking. The contention that this was an emergency situation was raised for the first time at the hearing. The incident report completed by Ms. Brown on the day of the child's injury did not mention the existence of an emergency situation, nor did she mention such a situation in her own handwritten report dated the next day, or during her later interview with the DHS investigator.[187] Danielle Sanders, who was present during the incident, also did not inform Ms. Martens or the DHS investigator that the child was in any immediate danger or that Ms. Brown acted to shield him from harm. Despite the suggestions of counsel at the hearing, there was no supporting report or testimony from Ms. Brown or other New Horizon personnel that Ms. Brown needed to move J.A. into the room quickly because the door was about to close and injure him, as his mother apparently informed the physician. And, despite Ms. Brown's apparent belief to the contrary, it is not reasonable to assume that J.A. would have been placed in imminent danger if he interacted briefly with the older toddlers in the next room, or that it was an emergency to quickly return him to the Busy Baby room. Moreover, while Ms. Brown's assertion during her hearing testimony that she did not let go of the child's arm because she was afraid he would fall and hit his head would perhaps offer some explanation for her conduct if she had simply

[185] T. 565, 570, 572.

[186] It appears that Ms. Sanders was not in a position to observe carefully what occurred. Her statement to the DHS investigator that J.A. was crawling on the floor at the time of the incident and Ms. Brown only put her arms down not touching the child as a guide to stop him from moving further into the toddler room (Exhibit 41) is not entitled to much weight because it was not only inconsistent with Ms. Brown's description of the incident but also with information given by Ms. Sanders to Ms. Martens the day after the incident occurred (Ex. 39) indicating that Ms. Brown either took J.A. by the hand or guided him back into the baby room by placing her hand on his chest or side.

[187] See Exs. 37, 38. 40.

continued to hold his arm, she took further action and proceeded to pull him back into the Busy Baby Room. Because no emergency existed, Ms. Brown was in a position where she could have protected the child from suffering nursemaid's elbow.

Based upon the medical references and hearing testimony, it is evident that pulling a child by the arms or hands may cause a dislocated elbow.[188] For the reasons discussed above, actions that may result in a dislocated elbow, such as pulling children by their arms, are appropriately considered to be actions that "seriously endanger" the child's health within the meaning of the Maltreatment of Minors Act. J.A. was in noticeable distress after the incident and was, in fact, diagnosed later that day as having suffered a dislocated elbow. The Department's determination that maltreatment by neglect occurred is supported by a preponderance of the evidence.

Responsibility for the Maltreatment: Facilities' Compliance with Related Regulatory Standards, Adequacy of the Facilities' Policies and Procedures, Facility Training, and the Employees' Participation in Training

Under Minn. Stat. § 626.556, subd. 10e(d), once maltreatment is found to have occurred, the Department (as the investigating agency)[189] is required to determine whether the individual employee or the facility itself is responsible for that maltreatment. The statute goes on to indicate in subdivision 10e(i) that the Department must consider certain "mitigating factors" in assessing the comparative responsibility of the facility and the employee. The only factor pertinent in the present case states that the Department must consider:

> comparative responsibility between the facility, other caregivers, and requirements placed upon an employee, including the facility's compliance with related regulatory standards and the adequacy of facility policies and procedures, facility training, an individual's participation in the training, the caregiver's supervision, and facility staffing levels and the scope of the individual employee's authority and discretion . . . .

There is no evidence that there were any shortcomings in the level of supervision of children by caregivers at the Elk River and Plymouth facilities. It appears that the areas of the facilities involved in this proceeding were adequately staffed by individuals who were acting within the proper scope of their duties and responsibilities. The primary factors to be considered here involve the Elk River and Plymouth facilities' compliance with related regulatory standards, the adequacy of their policies and procedures, facility training, and the employees' participation in the training.

[188] Exs. 12, 64-68; T. 290-292, 294, 302,305.
[189] *See* Minn. Stat. § 626.556, subd. 3c(a).

The Department determined that New Horizon's Elk River and Plymouth facilities were responsible for the maltreatment that occurred because it found that the facilities had failed to inform their staff and develop adequate policies and procedures about the dangers associated with swinging or pulling children by their arms. New Horizon contends that it is likely that it never received the 2002 Alert with its 2002 relicensing packet. It also asserts that the Department's determination amounts to an inappropriate attempt to penalize New Horizon for failing to provide training on a subject that is not specifically required by statute or rule. In response, the Department argues that the record as a whole supports the finding that the 2002 Alert was included in the relicensing packets sent for the Elk River and Plymouth facilities. The Department acknowledged that there is no licensing statute or rule that specifically mandates that child care facilities conduct training on nursemaid's elbow, and it cannot issue a citation to a licensed child care facility for not training its staff on the subject of nursemaid's elbow. However, the Department points out that it did not sanction New Horizon for failing to train its staff about the hazards of nursemaid's elbow in connection with these maltreatment determinations, but rather applied the statutory factors set forth above and found New Horizon culpable for the maltreatment that had occurred because it did not have any policies and procedures prohibiting staff from swinging or pulling children by their arms and had not provided staff with any training regarding the hazards of nursemaid's elbow.

Based upon all of the evidence in the record as a whole, the Administrative Law Judge concludes as a threshold matter that it is likely that New Horizon in fact did receive the 2002 Alert. The Department demonstrated that the 2002 Alert was sent with each reapplication packet in August or September of 2002, and New Horizon's corporate office would have received over 50 separate reapplication packets at that time. The cover memo sent with the licensing packet mentioned that the Department was "also enclosing a number of informational items" including "Alert – Dislocated Elbows."[190] The Alert was printed on a separate sheet with that title in bold print at the top of the page and the instruction to "Please alert your staff to the danger of dislocated elbows and take steps to prevent these types of incidents" in bold print at the bottom of the page.[191] And there is no evidence suggesting that the Department would somehow neglect to include the Alert in the relicensing packets sent in 2002 that were directed to already-licensed facilities.[192] Because there is no evidence that the Elk River or Plymouth facilities ever experienced a lapse in their licensure, it is more like than not that they received, completed, and returned their relicensing applications in a timely fashion.

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[190] Ex. 55 at page 2.
[191] Ex. 55 at page 10.
[192] Evidence that New Horizon was recently told by a DHS licensor that inclusion of the 2006 version of the Alert in packets sent to *new* facilities in *2006* was "hit and miss" (T. 634, 648-49) has no bearing on whether the 2002 Alert was sent to New Horizon's corporate office in *2002* in packets directed to *existing* facilities such as Elk River and Plymouth.

New Horizon's attempt to argue that it is more likely that the 2002 Alert was never mailed to New Horizon was not convincing. The testimony of its witnesses regarding receipt of the 2002 Alert was confusing and vague, and no direct testimony was provided at the hearing by corporate office staff who had first-hand knowledge on this point. Chad Dunkley, New Horizon's Chief Operating Office, merely testified that New Horizon Vice President Nola Kreml told him that she "did not see an Alert in the 2002 packet that she can recall."[193] He then more broadly indicated that "our staff do not remember getting a copy of the Alert."[194] Later in his testimony, he stated, "I believe a staff person in our office did see the [2002] Alert," but he did not specify who saw it or when.[195] He admitted that the Alert "was mailed to [Ms. Kreml] directly from licensing "at some point. Not in the fall of 2002."[196] He further testified that, upon receiving it, Ms. Kreml "immediately faxed it to all centers and told directors to make it part of their staff meeting agenda."[197] Again, he could not indicate when this occurred because he asserted that no record was kept.[198] Ms. Kreml did not testify at the hearing and no other New Horizon witness clarified when the 2002 Alert was received or whether it was received before or after the incidents at issue in this case. In addition, the Director of the New Horizon Plymouth facility, Tammi Martens, stated that she called New Horizon's corporate office when she realized that she did not have a copy of the Alert after J.A. suffered a dislocated elbow, and the corporate office promptly faxed her a copy of the 2002 Alert.[199] The Administrative Law Judge finds that the preponderance of the evidence shows that the Department provided New Horizon with the 2002 Alert containing information about the dangers associated with swinging children by their arms and pulling children by their arms.

After consideration of the parties' additional arguments, the Administrative Law Judge finds that the Department appropriately took into consideration in assessing the comparative responsibility of the facilities and the caregivers whether New Horizon adequately disseminated to its staff at the Elk River and Plymouth facilities the information about dislocated elbows contained in the 2002 Alert. It is true, as New Horizon points out, that there was no specific language included in the 2002 Alert mandating that the Alert be provided to staff or that staff be trained on the subject of the Alert, and there is no statute or rule that requires training on nursemaid's elbow (in contrast to statutes and rules requiring child care centers to train their staff members on certain other subjects, such as sudden infant death syndrome, shaken baby syndrome, first aid, and CPR).[200] However, the Department's rules do require more generally that child care facilities licensed by the Department develop policies that contain "safety

[193] T. 702.
[194] T. 704.
[195] T. 708.
[196] T. 708.
[197] T. 709; *see also* T. 723.
[198] T. 724.
[199] Exhibit 32 at DHS 21.
[200] *See* Minn. Stat. §§ 245A.144 and 245A.1445, and Minn. R. 9503.0035.

rules to follow in avoiding injuries"[201] and include "information about . . . procedures for maintaining health and safety" in the orientation training given to staff.[202]

The 2002 Alert was one of the first alerts ever issued by the Department. It informed facilities that there had been a number of reports of dislocated elbows caused by child care staff lifting or pulling children by their arms or hands, summarized two recent actions at child care centers that resulted in dislocated elbows, and described steps to reduce the likelihood of the injury. The 2002 Alert also asked facilities to read and share the Alert with their staff, let their staff know of the danger of dislocated elbows, and take steps to prevent these types of incidents. While there is no dispute that formal training on nursemaid's elbow is not mandated by statute or rule, the 2002 Alert did contain sufficient specific information from DHS about the injury and steps that should be taken to reduce the likelihood of that injury to warrant the inclusion of this information in orientation discussions about "procedures for maintaining health and safety" of children.

In addition, the language of the Maltreatment of Minors Act quoted above does not limit the Department's review solely to whether the facility has provided specific training that has been mandated by statute or rule. Rather, the Act requires the Department in broad terms to consider the facility's "compliance with related regulatory standards," "facility training," and "the adequacy of facility policies and procedures." As noted in the Conclusions above, one of the regulatory standards that applies to licensed child care facilities (Minn. R. 9503.0110, subp. 3(B)) requires them to develop policies that contain "safety rules to follow in avoiding injuries . . . ." The rule does not limit this obligation to the provision of safety rules on issues specifically set forth in the governing statute or in other rule provisions, but imposes a broader and more general duty to protect children from injuries.

After describing recent investigations involving children at child care centers receiving dislocated elbows, the 2002 Alert stated, in pertinent part:

> Because our investigations include a review of how the events could have been prevented, please read this alert, share it with your staff, and take the precautions that you feel are the best fit for your program. In addition to increased awareness and supervision by staff persons, the following may reduce the likelihood of this type of injury occurring:
>
> - Lift children by grasping them under their arms or around their bodies.

[201] Minn. R. 9503.0110, subp. 3(B).
[202] Minn. R. 9503.0035, subp. 1.

- Place arms around children's bodies and behind their heads and then lower them to the floor when they are struggling and throwing themselves to the floor.
- Never swing children of any age by their arms.
- Never grab, drag, pull, yank, swing, or lift children of any age by their arms or wrists.

Please alert your staff to the danger of dislocated elbows and take steps to prevent these types of incidents.[203]

There is no convincing evidence that New Horizon provided the information contained in the 2002 Alert to its staff in the Elk River or Plymouth facilities or gave them any information or training on the dangers of dislocated elbows prior to the incidents at issue in this case. At the time of these incidents, neither the Elk River facility nor the Plymouth facility had identifiable policies or procedures that warned of the risks of dislocating elbows and prohibited staff from swinging or pulling children by their arms. The "Lifting Safely" policy (Exhibit 23) posted at the facilities did not prohibit staff from swinging or pulling children by their arms or discuss the possibility of injuring children if that occurred, but was merely a reminder regarding how teachers should lift children to avoid back injury. The Behavior Guidance Policy (Exhibit 21) only addressed pulling arms in the context of corporal punishment or other discipline and did not warn of possible problems associated with swinging or pulling children by their arms or hands in a non-disciplinary context. The fact that New Horizon did not discipline the staff members involved in either of these incidents for violation of the Behavior Guidance Policy supports the view that the Behavior Guidance Policy simply did not apply in those circumstances.

None of the training materials provided to the DHS investigators in either case addressed swinging or pulling children by the arms or dislocated elbows. Ms. Fox, the Director of the Elk River facility, was not able to identify any document or training she provided on dislocated elbows or swinging children by their arms, and stated during the DHS investigation that she was not aware that she had ever seen the 2002 Alert.[204] Chad Dunkley, the Chief Operating Officer of New Horizon, acknowledged that the Elk River facility did not have a policy informing staff not to swing children by their arms at the time of the incident involving T.W., but he believed it was "common sense" not to do so. Ms. Fox agreed that Ms. Haugen probably would not have known that swinging was not allowed, but also expressed her view that it was "common sense" not to swing children around.

[203] Ex. 33 (emphasis in original).
[204] Ex. 7 at DHS 31; T. 403-04. Although Ms. Fox agreed in response to leading questioning at the hearing that she believes she had seen the 2002 Alert prior to the incident with T.W., that testimony is not convincing in light of the contrary information she provided during the investigation.

Ms. Haugen acknowledged during the DHS investigation that she had never seen the DHS Alert or otherwise received any information or training on the dangers associated with swinging children by their hands or arms, and did not know that she was not allowed to do so. In her hearing testimony, Ms. Haugen verified that she did not know she should not swing children by the arms at the time of the incident and that New Horizon had not given her any information on that subject.[205] Although Ms. Haugen provided inconsistent testimony at the hearing regarding whether or not she had received training from New Horizon before the incident that advised her that children should not be swung by the arms,[206] she ultimately acknowledged that she was not sure that she had any training at all specifically relating to swinging children, stating, "I honestly don't remember specifically what training I had received, whether it was on twirling or picking up or things like that."[207] It is logical to assume that the statements Ms. Haugen made during the DHS investigation about the nature of her training prior to the occurrence of the incident involving T.W. would be more accurate than those she made at the hearing nearly 2 ½ years later. Although Ms. Heidelberger testified during the hearing that she believed she had received some training not to pick up children by their arms, she admitted that she could not remember exactly which of her various daycare employers had told her that.[208]

Similarly, Tammi Martens, the director of New Horizon's Plymouth location, acknowledged during the maltreatment investigation that she could not find any verification that Ms. Brown was trained about the dangers of nursemaid's elbow. Ms. Martens cannot recall that she had ever seen the 2002 Alert prior to the incident involving J.A. and had to call New Horizon's corporate offices to obtain a copy. Ms. Brown also admitted during the Department's investigation that she had never seen the DHS alert and was never trained on the information in the 2002 Alert. [209]

The Administrative Law Judge thus concludes that New Horizon's Elk River and Plymouth facilities were properly found culpable for the maltreatment that occurred at those facilities because they failed to inform their staff and develop adequate policies and procedures about the dislocation risks associated with swinging and pulling children by their arms. New Horizon's policies, procedures, and training were not adequate to ensure that its staff knew behaviors that must be avoided in order to protect the health of children in their care.[210]

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[205] T. 329, 331.
[206] *See, e.g.,* T. 341, 342, 343, 352, 360, 366, 378.
[207] T. 379.
[208] T. 319-20.
[209] Ex. 32; T. 595.
[210] Although there was some evidence that some first-aid training courses may have covered the subject of the DHS alert, there is no evidence that Ms. Brown or Ms. Haugen attended those particular courses.

While the Department has made a sufficient showing to support its finding that maltreatment by neglect occurred on May 14, 2004, and February 22, 2005, for which New Horizon was responsible, the Administrative Law Judge finds somewhat troubling the Department apparent failure to underscore to facilities the importance of disseminating the information contained in the 2002 Alert to their employees. The 2002 Alert was issued on only one occasion (August or September 2002), 21 to 30 months prior to the occurrence of these incidents in May 2004 and February 2005, as part of facility relicensing packets. The Department did not specifically mandate that the 2002 Alert be posted anywhere in child care facilities or included in safety policies or employee training. In addition, the 2002 Alert did not include a specific warning that failure to consider this area in the facility's overall safety plan may result in findings of maltreatment should incidents occur, as did later versions.[211] There is no evidence that the subject matter of the 2002 Alert was discussed in any fashion during subsequent licensing reviews or that the Department made any inquiry concerning what, if any, effort had been made by facilities to disseminate the information in the Alert to staff. Finally, the 2002 Alert was not mentioned at all in numerous other maltreatment determinations involving dislocated elbows that were issued by DHS after August 2002, and the vast majority of those determinations analyzed the situation under a "physical abuse" maltreatment standard rather than a "neglect" standard.[212] These are factors that the Commissioner may wish to take into consideration in rendering the final decision in this matter.

B.L.N.

[211] *See e.g.,* Ex. 62 at 279.
[212] Ex. 63.